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**JUNE 1978**

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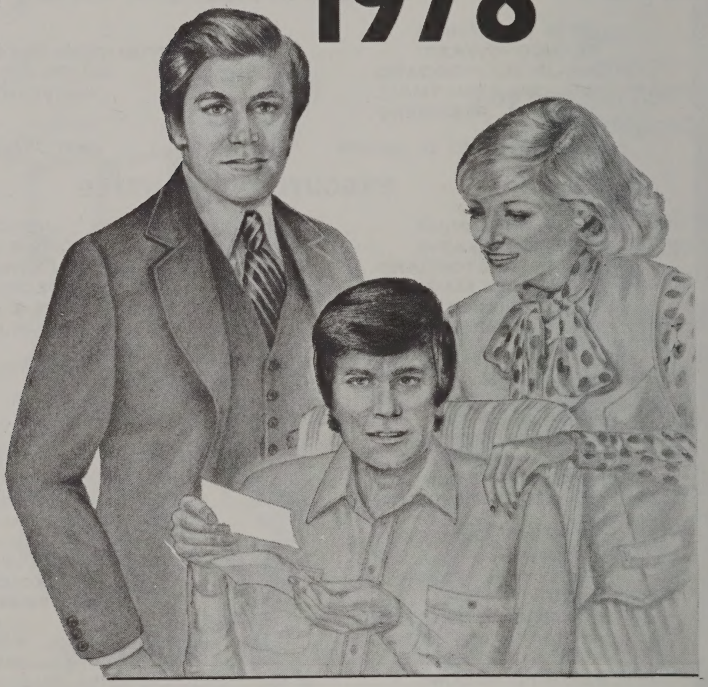

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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.
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# PRESIDENT'S PAGE
## California - Here We Come

For awhile it appeared as though the Malpractice Problem was reducing itself to manageable dimensions but recently the Massachusetts Medical Community was sent reeling by an award of $3,000,000. (I assume $3,000,000 that is $3,000,000 for the aggrieved and $1,500,000 for the successful attorney.) I would not attempt to offer an opinion on this case since I know nothing about it. However a few comments about the general problem may be made.

There can be little doubt that patients are occasionally, grievously injured as a result of medical treatment, or lack of it. There is occasionally blatant malfeasance on the part of the physician - other times it requires all the Machiavellian talents of a legal casuist to conjure up a real or imagined injury. There are all gradations in between.

Let's face it - Malpractice is a "rip-off" on the medical consumer and/or those who pay his bill. A physician in general does not lose money on malpractice. In fact, he may profit financially on the process. When the malpractice rates go up, he just raises his fees to compensate for this and maybe a little extra to be sure. He also may do extra lab work which may be a little renumerative and may call the patient back more often. For the dollar which he contributes to the malpractice larder the hapless patient collects between ten and twenty cents depending on whose statistics you read, a very poor investment indeed.

The tragedy of the malpractice lunacy as far as the physician is concerned is not financial but rather physical and emotional. Many a medical career and life have been ruined by a malpractice suit. The medical practitioner must, by the very nature of the work which he performs project a Messianic image. We all know when the patient says he "has all the confidence in the world in you doctor" he really has none but is trying to build up a little in himself. The doctor must therefore present a picture of consummate wisdom and skill. When the all knowing image of the doctor is shattered in a courtroom drama, the physician is often shattered as well.

What can we do about the malpractice problem? The step which has been taken by the Commonwealth requiring a review of all proposed malpractice suits has certainly been outstanding. For our part, we should not attempt procedures for which we are not equipped by training or experience; we should not get too busy - there are a lot of young people coming along who can use a little business. We should not be afraid to call in consultants - none of us knows everything - a consultation is often less expensive and much more rewarding than some sophisticated diagnostic test. A consultant is a good ally to have when a plaintiff's attorney is bearing down on you. Lastly, we might spend a moment or two, explaining to the patient what he is getting for his malpractice dollar. Anyone of them with the most remote knowledge of economics should be appalled. □

**JOHN J. FLAHIVE, M.D.**

# EXECUTIVE COMMITTEE

The Executive Committee met on Monday, June 5, 1978 in the Conference Room of the HDMS.

Present were Drs. Flahive, Walthall, Stoddard, Sachsse, Remsberg, Navazio, Corsaro and Mrs. Purdy. Dr. McKenna, dentist was also present.

The meeting was called to order at 7:30 P.M. by Dr. Flahive.

Minutes of the May meeting were read and approved as read.

**Correspondence**

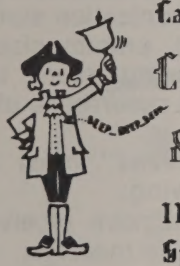
The American Association of Medical Society Executives wrote thanking HDMS for their donation of $50.00 for educational purposes.

A letter of inquiry from the South End Community Health Center for names of physicians for part time work at the center was read. A notice of this will be printed in the Hampden Hippocrat.

Places for meeting and speakers for 1978-1979 District Meetings were discussed.

Mrs. Purdy gave a report of the Council meeting held on May 31, 1978. She also gave the office report.

The meeting was adjourned at 9:10 P.M. □

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# "TO ARMS"

A recent communique from the Massachusetts Department of Public Health with endorsement and support of the Massachusetts Department of Education outlines a mandatory, all-out campaign to wipe out diphtheria, tetanus, whooping cough, polio, and measles as well as mumps and german measles incidentally. Inasmuch as studies have revealed that there is a large number of children in Massachusetts' schools who are not fully immunized, both departments are determined to stringently enforce the so-called School Immunization Law (Chapter 76, Section 15 of the General Laws). Moreover, the Massachusetts Attorney General has ruled that this law applies to all school children through grade twelve and not just those entering school.

PHYSICIAN RESPONSIBILITY

This School Immunization Law specifically requires one or more certificates from a physician (a parent in case of a religious exemption) that a child has been "successfully immunized" or exempted for health reasons against diphtheria, tetanus, pertussis, polio, and measles on an annual basis. The term "successfully immunized" means immunized against these diseases in accordance with the recommended schedules as published by the Massachusetts Department of Public Health or a disease specific diagnosis by a physician.

A physician's certificate is the only acceptable evidence of immunization or disease. School children without a physician's certificate on file with their school health record must be evaluated by a physician to determine immunization status. If no immunization status can be determined, the child will be considered unimmunized. Certificates provided by physicians must contain as a minimum, the month, the year, and the type of immunization or the occurrence of a clinical disease.

Children to be considered "successfully immunized" must be appropriately immunized in accordance with the following:

1. If they are six years of age or over, they must have received three tetanus/diphtheria (TD), three polio and one measles;
2. Children under the age six entering kindergarten must have four diptheria/tetanus/pertussis (DTP) plus three polio and one measles;
3. If the completion of the DTP series should continue after six years of age, or a booster is needed, then tetanus/diphtheria (TD) is substituted for DTP.

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In the case of measles, children must receive one dose of measles after 15 months of age. Children cannot be considered adequately protected and should be reimmunized:

1. If they were immunized before one year of age;
2. If they were immunized prior to January 1, 1966;
3. If they were previously immunized with killed measles vaccine;
4. If they received live, further attenuated vaccine (Schwartz R. or Moraten R strains) along with immune serum globulin (ISG) regardless of age of vaccination.

ATTACK PLAN

To implement this enforcement program, school authorities - public, private and private independent - are requested to review the immunization records of all children in grade one through grade 12 and where necessary to advise parents as to the immunizations required. Moreover, documentary proof of immunization shall be required for continued school attendance after October 20, 1978. As a result of this action, the number of exclusions from school and the number of children in the process of completing their required immunizations within a prescribed time interval are required to be reported to the Massachusetts Department of Public Health, so that constant vigilance on the program's progress can be maintained.

In the coming months, physicians can expect a deluge of requests from parents for documentary evidence of immunizations and/or specific disease morbidity, as well as immunizations. Hopefully, the

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logistics of providing documentary evidence of immunization or specific disease morbidity will not become overwhelming to physicians. Insofar as immunologicals are concerned, measles vaccine for girls over 13 years of age, measles-mumps-rubella vaccine for girls under 13 years of age and all boys, polio vaccine, DTP, and TD will be available to physicians free of charge from official public health agencies.

To obtain the needed biologicals, physicians in private practice must, by federal government mandate, sign a "Physician Certification Form" signifying that they "will exercise individualized medical judgment" or "will provide to each patient (parent or guardian) receiving such vaccine a copy of the appropriate "Important Information" form dated December 1, 1977". The said "Important Information" forms are in essence informed consent forms similar to those utilized in the Swine Flu immunization program. Supplies of same can be obtained from the official local health agency supplying the immunologicals.

Those physicians opting to use the "Important Information" forms are to retain the signed bottom portion thereof in their files until they receive written notice that retention is no longer required. Moreover, the said physicians upon request will have to furnish copies of these signed portions to the official local public health agency or the Center for Disease Control, U.S. Department of Health, Education and Welfare. No vaccine will be distributed to physicians until they have signed such a "Physician Certification Form", which will be kept on file by the official local public health agency. Only one such form need be signed by each physician.

All health service facilities providing immunizations have no option but to use the said "Important Information" forms and retain the bottom portion as signed by the patient (parent or guardian) in their files until advised that retention is no longer necessary. The upper portion of this form is intended to inform the patient (parent or guardian) as to the risks and benefits of each vaccine.

And so, with the compliments of your government, enjoy! □

**JOHN C. AYRES, M.D.**


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# WHAT ARE WE PREVENTING?

For many moons the continuing debate on the matter of how to contain and eventually reduce the cost of hospital care in the United States has centered around the issue of prevention of disease. If only we could keep the citizenry from getting sick or injured those individuals would not require hospitalization and, quod erat demonstrandum, hospitals would pine away, sink into a desuetude, and doctors, nurses, technicians, maintenance crews along with well-intentioned trustees would become obsolescent so that fiendishly expensive, extravagant institution, the general hospital, would simply crumble away.

The solution to the problem therefore is simplicity itself. Just eliminate preventable hospital admissions and millions of dollars in tax-payers' money, insurance premiums, and individual pay-outs never need be handed over to in-efficient hospital administrators and their wasteful employees and staffs. Somehow the health funderss, the medical economists, the bureaucrats, and the free lance writers become very vague when the question is put to them bluntly: what are you going to prevent and how do you propose to accomplish it? After mumbling about the generally accepted procedures regarding control of hypertension and diabetes, and the relationship between cigarettes and lung cancer and emphysema, they suddenly become mute.

The present discussion is neither scholarly nor scientific. Its intent is to raise questions rather than offer solutions. But its intent also is to stimulate some serious research into the whole problem of feasible preventive measures as they relate to general hospitals. (The specialized hospitals have special problems and for the most part they have escaped the vehement criticism heaped on the others.) If there are feasible preventive measures, is it a prime responsibility of the physician to put them into practice?

In an attempt to get a beginning insight into this issue, data was obtained from a regional hospital concerning the 20 most frequent admission diagnoses for the period from October 1, 1975 to September 30, 1976. One important explanatory note is in order. Because malignancy is classified according to the primary organ involved, lung cancer is the only one that appears on the list, otherwise malignant disease would stand very high on the roster. Similarily trauma is categorized according to the tissue injured or the bone fractured instead of lumping all such as an entity. Again, accidental injuries would be a leading cause of hospital admissions. With these disclaimers the list is as follows:

1. Delivery (obstetrical)
2. Disorder of menstruation
3. Anxiety neurosis, depression and other psychiatric diagnoses

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10. Diabetes mellitus
11. Diarrheal diseases, with gastroenteritis and colitis
12. Cholelithiasis
13. Abdominal pain
14. Asthma
15. Bronchitis/bronchiolitis
16. Calculus of kidney or ureter
17. Other diseases of lung (pneumonia, etc.)
18. Acute myocardial infaction
19. Hyperplasia of prostate
20. Cancer of bronchus/lung

It is worthy of note than when statewide figures are compared (the figures available are from April 1, 1974 to March 31, 1975) although the order of incidence may vary, sixteen identical diagnoses appear in the list of twenty most common, and all but one of the remaining four may be due to variance in nomenclature.

One objection that is bound to be raised to any conclusions from statistics such as these is that hospital admissions are much different from hospitalization, and that a multitude of cataracts or dental problems could be handled in the in-hospital time spent by one acute gall bladder or fractured hip, but the arguement is bootless if none is preventable.

No attempt was made to review hospital records to determine in how many instances control of sociological factors, industry safeguards, avoidance of smoking, abstinence from alcohol, control of obesity, or reduction of car speeds would have prevented these hospital admissions.

Sixty-five years ago Dr. Milton J. Rosenau of the Harvard Medical School authored a volume entitled PREVENTIVE MEDICINE AND HYGIENE which was to become a classic and run to several editions. It is worthy of note that in 1913 the problems foremost in the minds of the leaders in the field of preventive medicine and public health were overwhelmingly those due to microorganisms. Dr. Rosenau dealt at length with smallpox, rabies, veneral disease, tetanus, typhoid fever, cholera, dysentery, tuberculosis, diphtheria, scarlet fever, whooping cough and poliomyelitis. There is no more graphic demonstration of the enormous advances in public health in the twentieth century than the realization that most physicians educated since World War II have never seen a case of many of these diseases.

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It is important to point out that these ailments were controlled or eliminated by vaccines, antisera, antitoxins, isolation, to a slight extent by antibiotics, and by legislation; legislation to control dogs, water and milk supplies, veneral contacts, tuberculous cattle and other hygienic factors. But are we to assume that our Congressmen and our bureaucrats are convinced that all that is required at the present day to cut down on hospital admissions is to pass laws and spend money?

Perhaps the etiologic factors facing the present generation are unlike those of the earlier days of this century. There may, of course, be legislative answers to such medical problems as menstrual disorders, gall stones, cataracts, hernias, fibroids, pulmonary infections, prostatism and the like and possibly diarrhea and asthma can be outlawed, but it will take jurists with wider experience than most to draw the legislation.

There are those who maintain that education will become a major factor in disease prevention, but who is to do the educating and what shall they teach? Secretary Califano of HEW says that he quit chain smoking because his eleven year old son learned in grammar school that it was bad for his health. It's nice to know that a man in a position to have such a profound impact on medical practice as Secretary Califano is educable, but who taught his predecessors about cyclamates, saccharin and swordfish?

There is no attempt here to be derogatory about the many sincere efforts being made to control or eliminate disease or injury through screening clinics, educational programs, exercise programs, advertising or legislation aimed at accident prevention. But it is not the responsibility of the practicing physician to alter the life-style of the American people. There are many health problems that are not medical problems. □

**HOWARD N. SIMPSON, M.D.**

# MAMMOGRAPHY
## Recent Developments and Current Status

The value of mammography (using either xerography or low dose film technique) in diagnosis of breast disease is well established. Additional modalities are available: Thermography as a screening examination, and ultrasound study of the breast which, however, is still considered in an experimental phase.

It is known that large amounts of radiation to the breasts, either as a single exposure or given cummulatively, may have a cancerogenic effect. It is not known that there is a threshold dose for carcinogenesis, nor is it possible to tell that there is a linear relationship between development of breast cancer and total radiation dose delivered to the breast. Nevertheless, recent publications, both in the lay press and professional literature, by Bailar, Breslow and Bross suggest that mammography as used today may cause a statistically significant number of breast cancers in the future. These authors also suggest that routine screening examinations in asymptomatic women under 50 years of age not be performed.

A proposed policy for performance of mammography, as recommended by the Committee on Mammography of the American College of Raiology, is as follows:

A. Mammography should be performed if clinical findings indicate a significant suspicion of mammary cancer.
B. Mammography should not be performed in women under the age of 35 except when there are specific, strong clinical indications. The incidence of carcinoma in this age group is very low. There are, however, occasional circumstances in which mammography in women under the age of 35 is justified.

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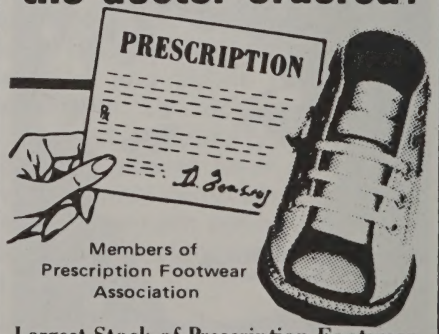


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C. A baseline mammogram should be performed during the age period 35-40 years in the following high risk category:
   1. Chronic cystic mastitis with or without pain
   2. Lumps and thickening in the breasts
   3. A personal history of breast cancer on the maternal or paternal side
   4. A family history of breast cancer in sisters
   5. Early onset of menstruation
   6. No history of pregnancies
   7. First full-term pregnancy at 30 or older
   8. Breast surgery scheduled for diagnostic purposes
   9. Fear of cancer which requires reassurance of a negative examination

D. Periodic mammography with the examinations done with low level radiation factors may be performed in women between the ages of 35-49 but the periodicity of such examinations should be determined by an analysis of relative risk factors.

E. For women 50 years of age and older, annual or other periodic mammography has been statistically justified. For the occasional women with no risk factors and with breast mammograms demonstrating fatty replacement and hypoplastic ducts, rather longer intervals might be justifiable. For the woman at very high risk (e.g., previous history of breast cancer) more frequent examinations might be considered.

It is our strong belief that mammography as performed by modern standards, delivering less than one Rad and midplane dose to the breast for two exposures, should be performed applying above delineated criteria. Benefits in terms of early diagnosis of malignancy, either clinically suspected or unsuspected, far outweigh theoretical risks. □

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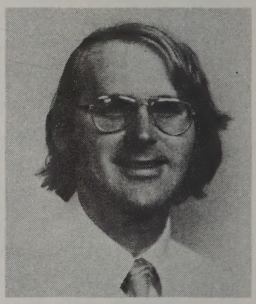
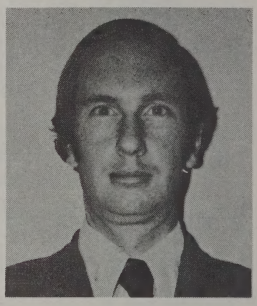


**JAMES F. HAINES, M.D.**, One Crane Park, Wilbraham, Mass. 01095. Born: September 13, 1945. Medical School; Georgetown University, 1971. Internship: St. Francis Hospital, Hartford, Conn., 1971-1972. Residency: St. Francis Hospital, 1972-1974. Specialty: Internal Medicine.



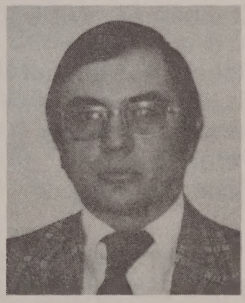
**WILLIAM A. HARBISON, M.D.**, 80 Congress St., Spfld, Mass. 01104. Born: December 25, 1944. Medical School: Columbia University, 1971. Internship: Columbia University at St. Luke's, New York, 1971-1972. Residency: MCGill University, Montreal General Hospital, 1974-1975, Cardiology Fellowship, 1975-1977. Specialty: Internal Medicine - Cardiology.

**STEVEN B. HOLSTEN, M.D.**, 50 Maple St., Spfld, Mass. 01103. Born: December 16, 1941. Medical School: Jefferson Medical College, 1967. Internship: Methodist Hospital, Philadelphia, 1967-1968. Residency: Thomas Jefferson University Hospital, Philadelphia, 1970-1974. Specialty: Orthopedic Surgery.

**VIJAY V. JOSHI, M.D.**, Baystate Medical Center, 140 High St., Spfld, Mass. 01105. Born: August 24, 1936. Medical School: B.J. Medical College, Poona, India, 1961. Internship: University of Bombay, 1962, Royal College of Obstetrics and Gynecology, England, 1969, Royal College of Physicians, England, 1970, Fellow of the Faculty of Anesthesiologists and Royal College of Surgeons, England, 1973. Residnecy: J.J. Hospital Bombay, India, 1961-1963. Specialty: Anesthesia.

**ANTOINE A. SAINT LOUIS, M.D.**, Baystate Medical Center, 140 High St., Spfld, Mass. 01105. Born: February 7, 1933. Medical School: Faculty of Medicine, 1956. Internship: Maisonneuve Hospital, Montreal, Canada, 1964-1965. Residency: Maisonneuve Hospital, 1965-1967, Georgetown University Hospital, Washington, 1967-1968. Specialty: Anesthesia.

**MARC J. SCHWEIGER, M.D.**, Baystate Medical Center, 759 Chestnut St., Spfld, Mass. 01107. Born: October 27, 1946. Medical School: S.U.N.Y. Upstate Medical Center, 1973. Internship: Boston City Hospital, 1973-1974. Residency: Boston City Hospital, 1974-1975, Fellowship-University Hospital, 1975-1977. Specialty: Internal Medicine-Cardiovascular Diseases.



**ROBERT J. WALAT, M.D.**, Noble Hospital, Silver St., Westfield, Mass. 01085. Born: July 5, 1942. Medical School: Yale School of Medicine, 1969. Internship: Yale-New Haven Hospital, 1969-1970. Residency: Yale-New Haven Hospital, 1970-1971, Yale-New Haven Hospital, 1973-1975. Specialty: Pathology.

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# Hampden District Auxiliary Officers

At the Annual Meeting of the Auxiliary to the Hampden District Medical Society, the slate of officers for 1978-1979 was voted upon and approved. The following officers will serve a one year term:

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PRESIDENT-ELECT
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Mrs. Gregory A. Slachta

Dear fellow members, after attending your Annual Meeting on Tuesday April 25, 1978 my faith has been renewed with the thought that "Volunteerism" is not dying out. I was overwhelmed by the support of over 150 members in attendance that day, especially after listening to the Annual Report given by your past president, Cynthia Bye, whose enthusiasm is shared by your new president Polly Miller (especially with the "Touch and See" program). I can honestly say that I am proud to be a part of such a worthwhile organization. Congratulations Hampden! Keep up the good work!! □

**MRS. LEONARD BOURAS**
**President**
**Massachusetts Medical Society Auxiliary**

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To The
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Last First

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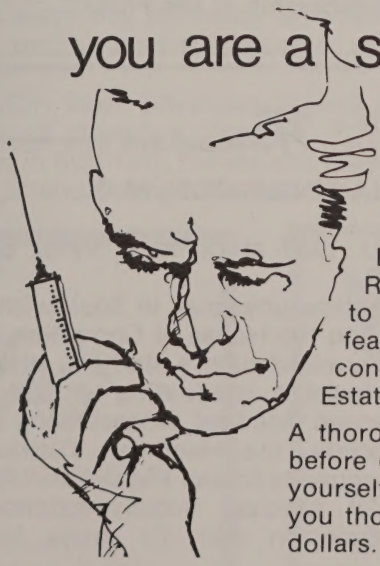

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## *In Memoriam*

### BERNARD CANTER, M.D.

Bernard Canter, M.D. died on June 4, 1978 in Baystate Medical Center.

Born in Boston, he attended Massachusetts Technology in Cambridge and Tufts Medical School, graduating in 1934. he interned at Wesson Memorial Hospital and was a private physician practicing in Springfield for forty two years.

Dr. Canter was a public health physician in the public schools and was a member of the AMA, MMS' and HDMS.

The members of HDMS extend their deepest sympathy to his family and many friends.

## *In Memoriam*

### LEO SCHWARTZ, M.D.

Born in Brooklyn, N.Y. he had lived in Springfield for forty three years. He graduated from Columbia University and earned his M.D. from Midddlesex College of Medicine in 1933.

He was a member of MMS, HDMS, the Academy of Medicine and was on the staff of the Mercy Hospital.

Deepest sympathy is extended to his family, friends and associates from the membership of the HDMS.

## *In Memoriam*

### ADRIAN DELERZON, M.D.

Adrian Delerzon, M.D. died at home in West Springfield, Sunday, April 30, 1978.

Dr. Delerzon was a longtime physician in Southwick, Agawam and Granville schools and the House of Correction.

Dr. Delerzon was a pharmicist before studying at Middlesex University School of Medicine, graduating in 1939. He was a member of the American Medical Association, the Massachusetts Medical Society, the Hampden District Medical Society and the Massachusetts School Physicians' Association.

The Hampden District Medical Society extends deepest sympathy to Mrs. Delerzon and his many friends and associates.

# PITFALLS OF LIQUID PROTEIN

In response to the recent display of emotional journalism regarding the Protein Sparing Modified Fast protocol, I feel compelled to communicate with my medical community via the Hippocrat.

First of all, let me set the record straight--Obesity is a serious medical problem among our patients who are 30-40 or more pounds overweight and the PSMF represents the only medical therapy when part of a multidisciplinary approach which demonstrates effectiveness for weight loss is excess of 40 pounds. In individuals with a body mass index above 30, this comprehensive approach also appears to be cost-effective.

As a member of the American Society of Bariatric Physicians, we do administer and adhere to its guidelines of a truly MULTIDISCIPLINARY APPROACH TO OVERT ADULT THERAPY (MAAOT) involving the etiology, physiology, and pathogenesis of obesity, nutritional counseling, role of exercise and physical activity, as well as behavior modification techniques. The term MAAOT really discribes what we are doing as an intense multidisciplinary educational effort. We have repeatedly warned that a narrow approach to abesity using only LIQUID PROTEIN is not only ineffective and uncostructive, but it is not becoming of a physician who is a member of our Society calls himself a BARIATRICIAN.

Furthermore when using this therapy properly, several hundred doctors have treated several thousand patients effectively. I am also proud to state that these doctors are primarily members of ASBP who specialize in the treatment of obesity and have participated in the required post-graduate education to become knowledgeable in the metabolism of fasting and this protocol.

Although the actual implementation of the following can be done in more than one way, the following are the ASBP guidelines for a comprehensive weight control program using the protein sparing modified fast.

1. ESTABLISH close physician/patient relationship, adequate to insure adherence to physician direction. Physician therapy is directed toward education in nutrition, fitness and lifestyle. The above should be documented by attendance and homework.

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2.PROVIDE the safe therapeutic use of fasting metabolism, including salt-linked water loss associated with ketosis and rapid weight loss. This includes proper characterization of the status of cerebrovascular, cardiovascular, renal and hepatic disease.

3. CHARACTERIZE the mental status of the patient by personality inventory, stress profile, and mood indices. Such characterization must be adequate to eliminate the patient whose lifestyle will not allow participating in a comprehensive weight control program.

4. INFORMED CONSENT adequate to establish an awareness in the patient of the unique responsibilities of the doctor/patient partnership.

5. MONITORING to include confirmation of the taking of 21 or more nutrients required to preserve body tissues except excess fat mass via documented patient report, inventory of nutrients taken every 30 days, necessary laboratory work and/or EKG tracings.

6. MAINTENANCE to include refeeding carefully monitored to restrict regaining of salt-linked fluid to less than three to five pounds per week.

7. FOLLOW UP which should include a schedule for refresher training quarterly.

8. DATA COLLECTION to include a method of recording results of treatment for future evaluation and reporting of data.

**[One example of a protocol to adhere to the above guidelines, and one that has not been associated with any untoward morbidity or mortality, is described in the following reference: Lindner, PG and Blackburn, GL: Multidisciplinary approach to obesity utilizing fasting modified by protein-sparing therapy. Obesity Bariat. Med. 5:198-216, 1976. A limited number of reprints are available to those physicians interested in this publication from the writer of this letter.]**

As you have read, there have been several deaths in patients who were on hypocaloric formula diets. This only emphasized the need for close medical supervision which the Society has repeatedly stated (see statement below). It appears from a preliminary examination of these tragedies that neither physician nor patient appreciated the importance of about 55 mequiv of potassium chloride or carbonate per day as a major key to the safety and effectiveness of the PSMF. The deaths occured in individuals losing more than one half pound per day for longer than 2 months and averaging 4 months. Such an excessive weight loss suggests that protein intake was either inadequate or was inadequately utilized due to micronutrient deficiencies (potassium is needed in order for the ingested protein to exert its protein sparing effect). There were 4 deaths in 1200 patients treated by Genuth and Vertes in Cleveland, one due to bubble gum aspiration (considered to be accidental) and the other 3 were known to have intercurrent cardiovascular disease. One patient in Cleveland under another physician's care was found to be hypokalemic on postmortem.

The remaining deaths have occurred scattered over various locations including Los Angeles, Texas, Michigan and Illinois. Although there was an attending physician involved in each case, there is no evidence that he was either knowledgeable in the metabolism of fasting patients who ingest liquid protein as their only source of food, or that he was more than just aware that the patient was on a "Liquid diet". The

unexplained deaths are consistent with electrolyte disorders shown by typical electro-cardiographic changes.

It appears, then, that the harm is done NOT by what physicians have been "doing", but by what they have NOT been doing! They are errors of ommision rather than commission. Particularly, ommitting an adequate potassium intake has probably led to the "unexplained" deaths. Additionally, what these physicians have ommitted is to participate with their patients (working in partnership) in a supervised multidisciplinary program because they have not yet come to the realization that a narrow approach to abesity wastes their patients time, effort, money, and, perhaps, even their health. The available data indicate that those patients who have not increased their awareness of nutrition, fitness (by exercise), or changed their lifestyle will regain their weight.

I would also like to put into perspective the risk/benefit ration of this protocol. Short of surgery their is, at present, no other program that is effective in reducing the risk of morbid obesity, which starts with excess weight of 40 or more pounds. It is certainly not cost-effective or risk-effective for patients with trivial obesity and thus precludes the use of the PSMF protocol for short term or minimal weight reduction therapy.

The above opinions are mine, and I take full responsibility for them, yet they are shared by many who are experienced in this method of therapy. The Society has taken an official stand as long ago as February, 1976, and that position is still being held at present, as there is no reason to change it. The recent events have only supported that this stand was a wise one, and I would like to conclude this memorandum by quoting it again so that you can appreciate its wisdom.

"The Protein Sparing Modified Fast can be a valuable tool in treating the obese in the hands of a qualified physician knowledgeable in this technique. However, the casual administration of this program by commericial clinics or other organizations where the supervision of patients by physicians is only cursory, can represent a serious threat to the health and welfare of the patient."

Because of the seveity of this unconventional approach for the treatment of obesity, its use should be reserved solely to specially trained and qualified physicians who personally monitor the progress of patients on a very frequent and regular basis. The administration of this program by anyone other than such a physician may threaten the very well-being of the patient."

In conclusion I'd like to submit a suggested memo:

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**TO ALL OUR PATIENTS:**

"Recent publicity regarding "liquid protein diets" may have generated a concern among many of you, your families and friends, and rightfully so. Since such an unsupervised consumption of low biological value "liquid protein" really has nothing to do with the type of comprehensive physician-monitored multidisciplinary approach to audit obesity program that we administer, we feel you are entitled to some comments on our viewpoint.

We have repeatedly asserted that obesity of the degree for which this program is indicated is a serious matter and the hazards must be weighed against the benefits from such therapy. To produce significant weight losses, short of surgery, a program that works has finally become available to patients who are at high risk of disease because of their obesity. We have also continuously advised you of the need for restructuring your lifestyle and wish to re-emphasize your need to participate in the education program, exercise, behavioral control techniques, and perform the assigned homework tasks in order to achieve meaningful results.

We are unaware of any deaths in patients who have participated in the type of program we describe. Liquid formula diets are safe when used with other necessary micronutrients in such a carefully structured setting. It is unfortunate that the casual administration of only one aspect of this program by physicians who are not knowledgeable in the complex mechanism of modified fasting has clouded the utility of this approach for the many desperate obese person who need the help that can be offered by this most effective and exciting advance in the rehabilitation of the obese person. If you or any of your family members wish to discuss this approach with me further and take a closer look at the facts, I would welcome the opportunity to do so." □

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# IN BRIEF

**Medical staff** chiefs of about 7,000 hospitals were urged in a letter from the AMA to adopt resolutions supporting the Voluntary Effort - the national Voluntary Cost Containment Program organized by the AMA, the American Hospital Assn., and the Federation of American Hospitals. The program seeks to reduce hospital revenue increases by 2% a year over the next two years. "The medical profession's concern for the patient the AMA said, "makes it our responsibility to seek the maximum efficiency and economy in health care delivery which can be achieved without detriment to the quality of that care." Similar letters were sent by the AHA to hospital chief executive officers. □

**The AMA urged** fraud and abuse information officers in HEW's ten regional offices to develop working relationships with state medical associations. At a conference attended by representatives of medicine, federal and state government, and the media, the newly designated officials were briefed on their task of informing the public about enforcement of the new Medicare-Medicaid anti-fraud legislation. Government speakers on the program said a strong fraud and abuse prevention program is being planned. □

**The Board** of Trustees approved the concept of AMA Seasonal Meetings designed to offer a wide variety of educational programs. The proposal, prepared by the Council on Continuing Physician Education, provides for two Seasonal Meetings each year, in addition to the Winter Scientific Meeting and the Regional Meetings. The council is developing

## SPECIAL TO: Hampden Hippocrat

The Pioneer Valley Chapter of the American Red Cross, a United Way of Pioneer Valley Agency, and the Northeast Regional Red Cross Blood Program will institute a Pheresis program at their blood center located in the Springfield Hospital division of Baystate Medical Center on Thursday, June 1, 1978.

This new Red Cross service will specialize in plateletpheresis with a goal of two donors per day by July 1 and a capacity of three donors per day by August 1. Dr. A.W. Janes, associate medical director of the Northeast Blood Program said, "The program is being initiated in an effort to augment the Baystate Medical Center's already overburdened leukapheresis and plateletpheresis program, which has been in operation since 1971." The need for pheresis processed blood components is ever-increasing throughout the Pioneer Valley and Western Massachusetts.

William Phillips, Executive Director of this United Way of Pioneer Valley agency, said "Our local Red Cross chapter will be responsible for recruiting pheresis donors and maintaining all records pertaining to the donor, just as we do in our regular blood donor program." □

plans to work with specialty societies in programming the the Seasonal Meetings. □

**The nation's** medical schools this year will receive $1,150,000 in ama-ERF unrestricted grants. The grants are made possible by the contributions of individual physicians and medical societies, the fund-raising efforts of medical society auxiliaries, and donations from other wishing to support medical education. AMA-ERF grants to medical schools have averaged more than $1 million annually for the past 28 years. □

**AMA operating** revenues and other income were $60,924,652 in fiscal 1977 while operating expenses were $46,096,034. AMA EVP James H. Sammons, M.D., said, "The operating gain of $14,828,618 enabled us to continue to replenish our reserves as directed by the House of Delegates during our 1975 Annual Meeting," and permits the AMA to "look ahead with confidence." Dr. Sammons added that the priority now is "to give more attention to the Association's goals over the next decade." □

# TO: Members of the Hampden District Medical Society

The Pioneer Valley Chapter of the American Diabetes Association is making available a One-to-One Volunteer Program to provide Springfield area hospitals and their diabetic patients with an immediate opportunity to be in contact with other diabetics who have already made a good adjustment to the disease.

The area chairman of this program is Dr. Louis Izenstein and the volunteers are being trained by Sheila Garvey, R.N., diabetic teaching nurse at Springfield Hospital.

This service is a social and emotional orientation available to any diabetic whose physician gives his or her consent. Any physician wishing to have his patient visited by a volunteer may do so by contacting Pat Mansur at 525-4620. □

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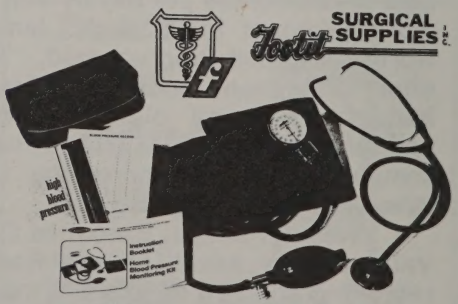


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# PHYSICIAN and MEDICAL ETHICS

Time was -- when life was much simpler -- that the ethical principles of a profession were those developed and administered solely by members of the profession. Now, as in the case of medical ethics, everyone is getting into the act. And -- the actors appear, at least on the present stage, to have more than walk-on roles.

As Robert M. Veatch pointed out in his **Case - Studies in Medical Ethics:** "Medical ethics is not restricted to physician ethics" -- not a particularly profound observation, but it may be a revelation to the ultra-conservative who is unaware that the practice of medicine now includes an increasing variety of issues, for example...

Informed consent, second opinion, abortion, definition of death, unnatural prolongation of life of the terminally ill patient (competent or incompetent), confidentialty of records and information, human experimentation, animal experimentation, hemodialysis allocation, pulling the plug, limitation of budgets of treating mental patients, certificate of need for physicians' offices, allocation of scarce medical tissues and resources, transplanting organs, referrals, cost containment, regulation of prescription writing, blood transfusion, third party payors and physicians fees and reimbursement, patient responsibility, advertising, practice location, type of practice, designated patients, directed medical curricula, etc.

And the participants in the issues are increasing, involving now --

Physicians, patients, nurses, hospital administrators, clergymen, lawyers, family, bureaucrats, medical students, orderlies, nurses' aides, consumer advocates, social workers, judges, representatives of federal and state regulatory bodies, and legislators.

It is suggested that there should be particular and immediate concern and reaction by physicians over the precipitious, heavy-footed and often clumsy intrusion of regulatory bodies into the act.

Control of medical practice (and medical ethics) by regulations imposed by a regulatory agency (the Board of Registration and Discipline in Medicine and the FTC are examples) will make physicians accountable not to their peers, but to a lay agency whose broad direction is specific, confining, expensive, naive, and counter-productive. The complete erosion of the free use of judgment in medical practice will be but a matter of time.

It is ironic that legislators who obviously have problems with developing and administering their own code of ethics would legislate ethical behavior for physicians. Laetrile is a case in point. A legislative proposal making it possible for a physician to "ethically" prescribe laetrile (a "drug" discredited by a federal agency) may in itself be unethical.

It is suggested that solutions to current, nagging problems of medical ethics not be sought in the regulatory agency or the legislature. Solutions do lie in the Code of Ethics of the Massachusetts Medical Society and the Principles of Medical Ethics of the American Medical association. □

**EVERETT R. SPENCER, JR.**
**Executive Secretary**
**Massachusetts Medical Society**

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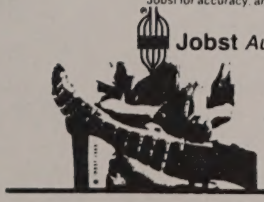

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